

- b. A final cost report for the period of July 1 through the end of the closeout period must be filed in accordance with 471 NAC 12-011.09. Schedules detailing the actual "unusual" costs incurred per a. above, and the actual daily census for the closeout period must also be submitted. Two final rates shall be computed:
- (1) For the closeout period - the identified "unusual" closeout cost and the prorated portion of total period costs shall constitute the total closeout period costs. Actual inpatient days for the closeout period are used to compute the per diem. Rates are not subject to the Direct Nursing, Direct Support Services, or Other Support Services maximums. The Administration expense limitation in 471 NAC 12-011.06N is waived, along with occupancy limitations in 471 NAC 12-011.06B;
  - (2) For the period prior to the closeout period - the rate shall be computed from the remainder costs/census in accordance with provisions of 471 NAC 12-011.07I;
  - (3) The Department shall retroactively adjust interim rates paid to the allowable rates computed per (1) and (2) above.

12-011.08 Depreciation: This subsection replaces Medicare regulations on depreciation in their entirety, except that provisions concerning sale-leaseback and lease-purchase agreements (Medicare's Provider Reimbursement Manual (HIM-15), Section 110) are retained, subject to the following Medicaid depreciation regulations.

At the time of an asset acquisition, the nursing facility shall use the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 1988 edition, to determine the useful life span. In the event that the nursing facility determines a useful life shorter than a life shown in the tables, the facility shall have documentation available to justify the unique circumstances that required the shorter life. In determining the allowable basis for a facility which undergoes a change of ownership or for new construction, see 471 NAC 12-011.06H and J.

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12-011.08A Definitions: The following definitions apply to depreciation:

Fair Market Value: The price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

Straight-Line Method: A depreciation method in which the cost or other basis (e.g., fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined and the balance of the cost is distributed in equal amounts over the assigned useful life of the asset class.

12-011.08B Buildings and Equipment: An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be -

1. Identifiable and recorded in the provider's accounting records;
2. Based on book value of the asset(s) in use before July 1, 1976. Book value for these purposes is defined as cost less depreciation allowed or allowable per American Hospital Association or Internal Revenue Service guidelines;
3. Based on the lesser of cost or fair market value at the time of purchase for a facility purchased or constructed after June 30, 1976. The basis for facility purchases or new construction may be subject to limitation (see 471 NAC 12-011.06H and J);
4. Based on the fair market value at the time of donation in case of donated assets. Depreciation on donated assets must be funded in order to be allowed; this requires that money be segregated and specifically dedicated for the purpose of replacing the asset; and
5. Prorated over the estimated useful life of the asset using the straight-line method of depreciation.

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12-011.08C Purchase of an Existing Facility: Unless there is a comprehensive appraisal by a Member of the Appraisal Institute (MAI), the Department uses the following guidelines to determine a reasonable allocation of the allowable basis to furniture and equipment for which "component" depreciation may be claimed.

<u>Classification</u>	<u>Variable for Under 40 Beds</u>	<u>Basic Cost Bases For 40 to 75 Beds</u>	<u>Variable for Over 75 Beds</u>
Moveable furniture	\$1,000 per bed	\$1,000 per bed	\$1,000 per bed
Dietary equipment	2 1/2% decrease to "Basic" for each bed	\$25,000	1% increase to "Basic" for each bed
Laundry equipment	"	\$20,000	"
Heating equipment	"	\$10,000	"
Air Cond. equipment	"	\$10,000	"

12-011.08D Recapture of Depreciation: Depreciation in 471 NAC 12-011.08D refers to real property only. A nursing facility which converts all nursing facility beds to assisted living beds is not subject to recapture provisions. A long term care facility which is sold for a profit and has received NMAP payments for depreciation, shall refund to the Department the lower of -

1. The amount of depreciation allowed and paid by the Department between October 17, 1977, and the time of sale of the property; or
2. The product of the ratio of depreciation paid by the Department since October 17, 1977, to the total depreciation accumulated by the facility (adjusted to total allowable depreciation under the straight-line method, if any other method has been used) times the difference in the sale price of the property over the book value of the assets sold.

Depreciation Paid by State      X      Sales Price - Book Value  
Accumulated Depreciation

If the recapture of depreciation in any or all years before August 1, 1982, would have resulted in additional return on equity as allowed by the reimbursement plan then in effect, the amount of return on equity must be offset against the amount of recapture.

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<u>Examples:</u>	<u>Data</u>	
1. Original Cost of Facility		\$400,000
2. Total Depreciation (S.L.) to date		\$100,000
3. Book Value of Facility (1-2)		\$300,000
4. Depreciation Paid Under Medicaid		\$ 35,000
5. Ratio of Depreciation Paid to Total Depreciation (4-2)		35%

Example A

Facility Sold For	\$500,000
Difference in the Sale Price Over the Book Value	\$200,000 (\$500,000 - \$300,000)
Medicaid Apportionment (35% X \$200,000)	\$70,000

The amount of depreciation recaptured on gain is \$35,000, the amount of depreciation previously paid under NMAP.

Example B

Facility Sold For	\$350,000
Difference in the Sales Price Over the Book Value	\$ 50,000
Medicaid Apportionment (35% X \$50,000)	\$ 17,500

The amount of depreciation recaptured on gain is \$17,500, which is the ratio of depreciation paid under NMAP for Medicaid clients (\$35,000) to total depreciation accumulated (\$100,000) times the amount of gain (\$50,000) on the disposition of real property.

12-011.08E Other Gains and Losses on Disposition of Assets: Losses on the sale of real property are not recognized under NMAP. Losses on the disposal of replaced building components that have been specifically identified in the nursing facility's depreciation schedule since acquisition will be included in the allowable fixed cost for the report period. Gains/losses on personal property will be reduced from/included in allowable fixed costs for the report period. Gains in excess of the other allowable fixed costs will result in a negative fixed cost component of the facility's rate.

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12-011.08F Sale or Transfer of Corporate Stock: Where the existing corporation continues after the sale or transfer of corporate stock, the depreciable basis of assets used under the program will be that of the then existing corporation. No revaluation of assets is allowed when only an acquisition of stock is involved.

12-011.09 Reporting Requirements and Record Retention: Providers shall submit cost and statistical data on Form FA-66, "Report of Long Term Care Facilities for Reimbursement" (see 471-000-41). Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation shall prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct/reduce/eliminate data. Providers are notified of changes.

Each facility shall complete the required schedules and submit the original, signed Report to the Department within 90 days of the close of the reporting period, when a change in ownership or management occurs, or when terminated from participation in NMAP. Under extenuating circumstances, an extension not to exceed 15 days may be permitted. Requests for extensions must be made in writing before the date the cost report is due.

When a provider fails to file a cost report as due, the Department shall suspend payment. At the time the suspension is imposed, the Department shall send a letter informing the provider that if a cost report is not filed, all payments made since the end of the cost report period will be deemed overpayments. The provider shall maintain levels of care if the Department suspends payment.

If the provider takes no action to comply with the obligation, the Department may refer the case for legal action.

If a cost report has not been filed, the sum of the following is due:

1. All interim payments made during the rate period to which the cost report applies;

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2. All interim payments made subsequent to the accounting rate period to which the cost report applies; and
3. Costs incurred by the Department in attempting to secure reports and payments.

If the provider later submits an acceptable cost report, the Department will undertake the necessary audit activities. Providers will receive all funds due them reflected under the properly submitted cost reports less any costs incurred by the Department as a result of late filing.

Providers shall retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period or until an audit started within the five years is finalized, whichever is later. Records relating to the acquisition and disposal of fixed assets shall be retained for a minimum of five years after the assets are no longer in use by the provider. The Department shall retain all cost reports for at least five years after receipt from the provider.

Facilities which provide any services other than certified nursing facility services shall report costs separately, based on separate cost center records. As an alternative to separate cost center records and for shared costs, the provider may use a reasonable allocation basis documented with the appropriate statistics. All allocation bases must be approved by the Department before the report period. Any Medicare certified facility shall not report costs for a level of care to the Department which have been reported for a different level of care on a Medicare cost report.

12-011.09A Disclosure of Cost Reports: Cost reports for all report periods ending October 30, 1990, or thereafter, are available for public inspection by making a written request to the Department of Social Services Audit Unit. The request must include the name (including an individual to contact), address, and telephone number of the individual or organization making the request; the nursing facility name, location, and report period for the cost report requested; and directions for handling the request (review the reports at the Department's Central Office; pick up copies at the Department's Central Office; or mail copies). The total fee, \$5.00 handling for each report requested and an additional \$5.00 for each report to be copied and an additional \$2.50 for each report to be mailed, must accompany the request. The nursing facility will receive a copy of a request to inspect its cost report.

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12-011.10 Audits: The Department shall perform at least one desk audit and may perform subsequent desk audits and/or a periodic field audit of each cost report. Selection of subsequent desk audits and field audits will be made as determined necessary by the Department to maintain the integrity of the Nebraska Medical Assistance Program. The Department may retain an outside independent public accounting firm, licensed to do business in Nebraska or the state where the financial records are maintained, to perform the audits. Audit reports must be completed on all field audits and desk audits. All audit reports will be retained by the Department for at least three years following the completion and finalization of the audit.

An initial desk audit will be completed on all cost reports. Interim rates and care classification maximums are determined after the initial desk audit is completed. Subsequent desk and field audits will not result in a revision of interim care classification maximums.

All cost reports, including those previously desk audited but excluding those previously field audited, are subject to subsequent desk audits. The primary period(s) and subject(s) to be desk-audited are indicated in a notification letter sent to the provider to initiate a subsequent desk audit. The provider shall deliver copies of schedules, summaries, or other records requested by the Department as part of any desk audit.

All cost reports, including those previously desk-audited but excluding those previously field-audited, are subject to field audit by the Department. The primary period(s) to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period otherwise open for field audit. The scope of each field audit will be determined by the Department but must be sufficiently comprehensive to ascertain that the cost report complies with the provisions of this section. The provider shall deliver to the site of the field audit, or an alternative site agreed to by the provider and the Department, any records requested by the Department as part of a field audit.

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The Department may not initiate an audit -

1. More than five years after the end of the report period; or
2. On a cost report which has been previously field-audited.

This does not preclude the Department from reopening an audit in accordance with 471 NAC 12-011.14 #1 or initiating an audit in response to a reopening in accordance with 471 NAC 12-011.14 #2 or when grounds exist to suspect that fraud or abuse has occurred.

12-011.11 Settlement and Rate Adjustments: When an audit has been completed on a cost report, the Department shall determine if an adjustment to the rate is required; if necessary, a settlement amount is determined. The facility will be notified of the settlement on an MC-7, "Explanation of Medical Claims Activity." Payment or arrangements for payment of the settlement amount, by either the Department or the provider, must be made within 45 days of the settlement notice unless an administrative appeal filed within the appeal period is also filed within the 45-day repayment period. (See 471 NAC 12-011.15 for an exception to the 45-day repayment period.) Administrative appeals filed after the 45-day payment period will not stay repayment of the settlement amount. The filing of an administrative appeal will not stay repayments to the Department for audit adjustments not included in the appeal request. The Department may adjust the interim rate for payments made after the audit completion.

The Department shall determine a final adjustment to the rate and settlement amount after the audit is final and all appeal options have been exhausted. Payment for any final settlement must be made within 30 days. If payment is not made, the Department shall immediately begin recovery from future facility payments until the amount due is fully recovered.

The Department shall report an overpayment to the federal government on the appropriate form no later than the second quarter following the quarter in which the overpayment was found.

12-011.12 Penalties: Under federal law, the penalty for making a false statement or misrepresentation of a material fact in any application for Medicaid payments and for soliciting, offering, or accepting kickbacks or bribes (including the rebate of a portion of a fee or charge for a patient referral) is imprisonment up to five years, a fine of \$25,000, or both. Similarly, making a false statement of material fact about conditions or operations of any institution is a felony punishable by up to five years imprisonment, a fine of not more than \$25,000, or both.

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12-011.13 Appeal Process: Final administrative decision or inaction in the allowable cost determination process is subject to administrative appeal. The provider may request an appeal in writing from the Director of the Department within 90 days of the decision or inaction. The request for an appeal must include identification of the specific adjustments or determinations being appealed and basis and/or explanation of each item. See 471 NAC 2-003 and 465 NAC 2-006 for guidelines for appeals and fair hearings.

After the Director issues a determination in regard to the administrative appeal, the Department will notify the facility of the final settlement amount. Repayment of the settlement amount must be made within 30 days of the date of the letter of notification.

12-011.14 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

"Reopening" means an action taken by the Director to reexamine or question the correctness of a determination or decision which is otherwise final. The Director is the sole authority in deciding whether to reopen. The action may be taken -

1. On the initiative of the Department within the three-year period;
2. In response to a written request from a provider or other entity within the three-year period. Whether the Director will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions; or
3. Any time fraud or abuse is suspected.

A provider does not have the right to appeal a finding by the Director that a reopening or correction of a determination or decision is not warranted.

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12-011.15 Change of Holder of Provider Agreement: A holder of a provider agreement receiving payments under this section must notify the Department 60 days prior to any change or termination regarding the holder of the provider agreement. If any known settlement is due the Department by that provider, payment must be made immediately. If the provider is subject to recapture of depreciation on the anticipated sale and/or if an audit is in process, the provider will be required to provide a guarantee of repayment of the Department's estimated settlement either by payment of that amount to the Department, providing evidence that another provider receiving payments under this section has assumed liability, or by surety bond for payment. All estimated or final amounts, regardless of appeal status, must be paid before the transfer of ownership.

The Department will not enter into a provider agreement with a new provider if there is an unpaid settlement payable to the Department by a prior provider of services at the same facility unless the new provider has assumed liability for the unpaid amount. Parties to a facility provider change may receive information about unpaid settlement amounts owed to the Department by making a written request.

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